Hill Country Therapy & Testing

Informed Consent, Limits of Confidentiality, Office Policies, and General Information Agreement

This form provides you, the client, with information that is additional to that detailed in the Notice of Privacy Practices and it is subject to HIPAA preemptive analysis.

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission except where disclosure is required by law.

WHEN DISCLOSURE IS REQUIRED OR MAY BE REQUIRED BY LAW: Some of the circumstances where disclosure is required or may be required by law are: where there is a reasonable suspicion of child, dependent, or elder abuse or neglect; where a client presents a danger to self, to others, to property, or is gravely disabled; when a client reports abuse or misconduct by other health care professionals; when a client's family members communicate to your therapist that the client presents a danger to others. Disclosure may also be required pursuant to a legal proceeding by or against you. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the records and/or testimony by your therapist.

HEALTH INSURANCE & CONFIDENTIALITY OF RECORDS: Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. If you so instruct your therapist, only the minimum necessary information will be communicated to the carrier. Your therapist has no control over, or knowledge of, what insurance companies do with the information she or he submits or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance or even a job. The risk stems from the fact that mental health information is likely to be entered into insurance companies' computers and is likely to be reported to the National Medical Data Bank. Accessibility to companies' computers or to the National Medical Data Bank database is always in question as computers are inherently vulnerable to unauthorized access.

LITIGATION LIMITATION: Due to the nature of therapeutic and evaluation services, and the fact that they often involve making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that, should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorney(s), nor anyone else acting on your behalf will call on your therapist to testify in court or at any other proceeding, nor will a disclosure of the records be requested unless otherwise agreed upon.

CONSULTATION: Your therapist consults regularly with other professionals regarding clients; however, each client's identity remains completely anonymous and confidentiality is fully maintained. Consultation among therapists occurs within the practice of Hill Country Therapy & Testing.

E–MAILS, CELL PHONES, COMPUTERS, AND FAXES: It is very important to be aware that computers and unencrypted e-mail, texts, and e-faxes communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. Be aware that phone messages are transcribed and sent your therapist via e-mail. Please notify your therapist if you decide to avoid or limit, in any way, the use of e-mail, texts, cell phones calls, phone messages, or e-faxes. If you communicate confidential or private information via unencrypted e-mail, texts or e-fax or via phone messages, your therapist will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and she or he will honor your desire to communicate on such matters. Please do not use texts, e-mail, voice mail, or faxes for emergencies.

RECORDS AND YOUR RIGHT TO REVIEW THEM: Both the law and the standards of your therapist's profession require that she keep records for at least 5 years. Unless otherwise agreed to be necessary, your therapist retains clinical records only as long as is mandated by Texas law. If you have concerns regarding the records, please discuss them with your therapist. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when your therapist assesses that releasing such information might be harmful in any way. In such a case, your therapist will provide the records to an appropriate and legitimate mental health professional of your choice. Considering all of the above exclusions, if it is still appropriate, and upon your request, your therapist will release information to any agency/person you specify unless she or he assesses that releasing such information might be harmful in any way.

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact Rebecca Sheehan between sessions, please leave a message at (512) 438-9152 and your call will be returned as soon as possible. Rebecca Sheehan checks her messages a few times during the daytime only, unless he or she is out of town. If an emergency situation arises, call 24-hour crisis line at 512-472-HELP (4357) or the Police: 911. Please do not use email or faxes for emergencies. Rebecca Sheehan may not always check his or her email or faxes daily.

PAYMENTS & INSURANCE REIMBURSEMENT: The Fee Agreement is attached.

If your therapist is in-network as a provider for your insurance, the client/responsible party is responsible for paying any co-pay or deductible at the time of service. If applicable, insurance will be billed, but the insurance reviews the final bill prior to deciding final coverage, and the client is responsible for any remaining balance. The insurance company may determine that the service is not medically necessary or covered; thus, the client is expected to self-pay any balance.

It is important for clients to verify insurance coverage prior to appointments. Not all issues/ conditions/problems are reimbursed by insurance companies.

If your therapist is out-of-network as a provider for your insurance, the client/responsible party is responsible for all fees. Clients who carry insurance should remember that out-of-network professional services are rendered and charged to the clients and not to the insurance companies. Unless agreed upon differently, your therapist will provide you with a copy of your receipt, which you can then submit to your insurance company for reimbursement, if you so choose.

It is your responsibility to verify the specifics of your coverage. If your account is overdue (unpaid) and there is no written agreement on a payment plan, your therapist can use legal or other means (courts, collection agencies, etc.) to obtain payment. Please notify your therapist if any problems arise during the course of assessment regarding your ability to make timely payments.

MEDIATION & ARBITRATION: All disputes arising out of, or in relation to, this agreement to provide assessment services shall first be referred to mediation, before, and as a pre-condition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of the therapist and the client(s). The cost of such mediation, if any, shall be split equally, unless otherwise agreed upon. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in Travis County, Texas in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed. Notwithstanding the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, your therapist can use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection proceedings shall be entitled to recover a reasonable sum as and for attorney's fees. In the case of arbitration, the arbitrator will determine that sum.

THERAPY AND SCOPE OF PRACTICE: Participation in therapy can result in a number of benefits to you. However, your therapist cannot predict all reactions to the therapeutic process. Some of the sessions will be interesting, and other sessions may be frustrating and difficult. If discomfort occurs, please notify your therapist so the issue can be discussed. Your therapist attempts to make the process a useful experience as much as possible. Your therapist provides neither custody recommendations nor medication nor legal advice, as these activities do not fall within his or her scope of practice.

TERMINATION: Your therapist will assess if she can be of benefit to you. Rebecca Sheehan does not work with clients who, in her opinion, she cannot help. In such a case, if appropriate, she will give you referrals that you can contact. If you choose to do so, upon your request and if appropriate and possible, your therapist will provide you with names of other qualified professionals whose services you might prefer.

DUAL RELATIONSHIPS: Not all dual or multiple relationships are unethical or avoidable. Therapy never involves a dual relationship that impairs your therapist's objectivity, clinical judgment or can be exploitative in nature. Your therapist will assess carefully before entering into non-sexual and non-exploitative dual relationships with clients. Your therapist will never acknowledge working with anyone without written permission. Many clients have chosen your therapist as their provider because they knew her before they sought assessment with her, and/or are personally aware of her professional work and achievements. Nevertheless, your therapist will discuss with you the often-existing complexities, potential benefits and difficulties that may be involved in dual or multiple relationships. It is your responsibility to advise your therapist if the dual or multiple relationship becomes uncomfortable for you in any way. Your therapist will always listen carefully and respond to your feedback and will discontinue the dual relationship if she finds it interfering with the effectiveness of the services or your welfare and, of course, you can do the same at any time.

IDENTIFICATION OF THE "CLIENT": In Couples Therapy, we identify the client or treatment unit as the "couple" or both members being treated. This means that the unit being treated is the couple themselves, not one person or the other. There are several implications with this:1. For Consent purposes: Both people will need to read and sign the informed consent. 2. For Fee purposes:a. Insurance: Though we will most likely be filing insurance under one person's name, the file itself will belong to both people or the "couple".b. Attendance: Because the client is the "couple" if one person cannot attend, regular Fail to Keep and Late Cancellation fees will incur. (see Fee Agreement)3. For Release purposes: In order to release information pertaining to records, we will need both members consent.4. For Court purposes: If records are subpoenaed, I will assert therapist-client privilege on behalf of the "client".

SOCIAL NETWORKING AND INTERNET SEARCHES: Your therapist does not accept friend requests from current or former clients on social networking sites, such as Facebook. Adding clients as friends on these sites and/or communicating via such sites is likely to compromise their privacy and confidentiality. For this same reason, your therapist requests that clients not communicate with her via any interactive or social networking web sites.

CANCELLATION: Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours notice is required for canceling an appointment. Unless we reach a different agreement, the full fee will be charged for sessions missed without such notification. (Most insurance companies do not reimburse for missed sessions.)

I have read the above Informed Consent, Limits of Confidentiality, Office Policies, and General Information Agreement. I understand and agree to comply:

Client Name (print) _____

Signature _____

Date _____

Therapist Rebecca Sheehan has reviewed this information with responsible party.

Signature _____

Hill Country Therapy & Testing

Patient Confidential Communications

The Health Insurance Portability and Accountability Act (HIPAA) gives you the right to request that your therapist communicates financial and/or medical information to you in confidence by a particular method or certain locations.

In order to protect the privacy and confidentiality of your information; please complete the following which tells me how you would like to be contacted.

I wish to be contacted in the following manner (check all that apply):

Phone Communications

____ Home Telephone Number _____

____ Work Telephone Number _____

____ Cell Phone Number _____

____ Leave message--name of your therapist and call-back # on answering machine

____ Leave message with medical information on answering machine

____ OK to give information/leave message with following family member(s), friend/s or co-workers, or others listed below

_____

Written Communication

___ Mail information to my home address on file

___ Mail to my work/office address on file

___ Mail information to other address:

List _____

___ Fax to the following number _____

___ You can communicate via E-mail with me at _____

Your therapist will continue to communicate with you according to your above response(s) until you change your preferences. You may do so by completing a new form.

By your signature below, you agree to be communicated in the above manner.

Client/Parent/Legal Guardian Signature _____

Printed Name _____ Date _____

Hill Country Therapy & Testing
AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

Name of client _____**Date of Birth**_____

Address_____

I authorize **(Name)** _____

(**Address/Phone**)_____

to _____disclose _____ receive _____ exchange information about/discuss

__ Medical Records
__ Neuropsychological Assessment
__ Psychological Assessment
__ Psychiatric Evaluation
__ Academic Records (progress reports, testing, rating scales, 504 Plan, IEP)
__ Speech/Language Evaluation
__ Occupational Therapy Evaluation
__ Therapy Records/Clinical Information
__ Progress Reports
__ General Communication
__ Other:

to **(Name)** _____

(**Address/Phone**)_____

for the purpose of _____.

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time. I understand that this authorization shall expire in one year from the date below.

The provider shall not condition treatment upon client signing this authorization and client has the right to refuse to sign this form.

Client understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule.

Client/Parent/Authorized Guardian signature:_____

Date:_____ A copy of this form is as valid as the original.

HIPAA NOTICE OF PRIVACY PRACTICES

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

II. IT IS MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

By law I am required to insure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this Notice about my privacy procedures. This Notice must explain when, why, and how I would use and/or disclose your PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this Notice.

Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time as permitted by law. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will immediately change this Notice and post a new copy of it in my office**.** You may also request a copy of this Notice from me, or you can view a copy of it in my office**.**

III. HOW I WILL USE AND DISCLOSE YOUR PHI.

I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples.

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent.

I may use and disclose your PHI without your consent for the following reasons:

1. For treatment/assessment. I can use your PHI within my practice to provide you with mental health treatment/assessment, including discussing or sharing your PHI with my trainees and interns. I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, I may disclose your PHI to her/him in order to coordinate your care.

2. For health care operations. I may disclose your PHI to facilitate the efficient and correct operation of my practice. Examples: Quality control - I might use your PHI in the evaluation of

the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. I may also provide your PHI to my attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.

3. To obtain payment for treatment. I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you. Example: I might send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided to you. I could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for my office.

4. Other disclosures. Examples: Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.

B. Certain Other Uses and Disclosures Do Not Require Your Consent. I may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. **When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement.** Example: I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
2. **If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.**
3. **If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.**
4. **If disclosure is compelled by the patient or the patient's representative pursuant to Texas Health and Safety Codes or to corresponding federal statutes of regulations**, such as the Privacy Rule that requires this Notice.
5. **To avoid harm.** I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public (i.e., adverse reaction to meds).
6. **If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.**
7. **If disclosure is mandated by the Texas Child Abuse and Neglect Reporting law.** For example, if I have a reasonable suspicion of child abuse or neglect.
8. **If disclosure is mandated by the Texas Elder/Dependent Adult Abuse Reporting law.** For example, if I have a reasonable suspicion of elder abuse or dependent adult abuse.
9. **If disclosure is compelled or permitted by the fact that you tell me of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.**
10. **For public health activities.** Example: In the event of your death, if a disclosure is permitted or compelled, I may need to give the county coroner information about you.

11. **For health oversight activities.** Example: I may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.
12. **For specific government functions.** Examples: I may disclose PHI of military personnel and veterans under certain circumstances. Also, I may disclose PHI in the interests of national security, such as protecting the President of the United States or assisting with intelligence operations.
13. **For research purposes.** In certain circumstances, I may provide PHI in order to conduct medical research.
14. **For Workers' Compensation purposes.** I may provide PHI in order to comply with Workers' Compensation laws.
15. **Appointment reminders and health related benefits or services.** Examples: I may use PHI to provide appointment reminders. I may use PHI to give you information about alternative treatment options, or other health care services or benefits I offer**.**
16. **If an arbitrator or arbitration panel compels disclosure,** when arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.
17. **If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law.** Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.
18. **If disclosure is otherwise specifically required by law.**

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in Sections IIIA, IIIB, and IIIC above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that I haven't taken any action subsequent to the original authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

These are your rights with respect to your PHI:

A. The Right to See and Get Copies of Your PHI. In general, you have the right to see your PHI that is in my possession, or to get copies of it; however, you must request it in writing. If I do not have your PHI, but I know who does, I will advise you how you can get it. You will

receive a response from me within 30 days of my receiving your written request. Under certain circumstances, I may feel I must deny your request, but if I do, I will give you, in writing, the reasons for the denial. I will also explain your right to have my denial reviewed.
If you ask for copies of your PHI, I will charge you not more than $.25 per page. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.
B. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.
C. The Right to Choose How I Send Your PHI to You. It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). I am obliged to agree to your request providing that I can give you the PHI, in the format you requested, without undue inconvenience. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.
D. The Right to Get a List of the Disclosures I Have Made. You are entitled to a list of disclosures of your PHI that I have made. The list will not include uses or disclosures to which you have already consented, i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years.

I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous six years unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no cost, unless you make more than one request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional request.
E. The Right to Amend Your PHI. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if I find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to your PHI.

F. The Right to Get This Notice by Email. You have the right to get this notice by email. You have the right to request a paper copy of it, as well.

V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If, in your opinion, I may have violated your privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to file a complaint with the person listed in Section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about my privacy practices, I will take no retaliatory action against you**.**

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact: Rebeca Sheehan at Hill Country Therapy & Testing, 1021 Ranch Road 620, Suite B, Lakeway, TX 78734. (512)920-3356.

VII. NOTIFICATIONS OF BREACHES

In the case of a breach, Rebecca requires to notify each affected individual whose unsecured PHI has been compromised. Even if such a breach was caused by a business associate, Rebecca is ultimately responsible for providing the notification directly or via the business associate. If the breach involves more than 500 persons, OCR must be notified in accordance with instructions posted on its website. Rebecca bears the ultimate burden of proof to demonstrate that all notifications were given or that the impermissible use or disclosure of PHI did not constitute a breach and must maintain supporting documentation, including documentation pertaining to the risk assessment.

VIII. PHI AFTER DEATH

Generally, PHI excludes any health information of a person who has been deceased for more than 50 years after the date of death. Your therapist may disclose deceased individuals' PHI to non-family members, as well as family members, who were involved in the care or payment for healthcare of the decedent prior to death; however, the disclosure must be limited to PHI relevant to such care or payment and cannot be inconsistent with any prior expressed preference of the deceased individual.

IX. Individuals' Right to Restrict Disclosures; Right of Access

To implement the 2013 HITECH Act, the Privacy Rule is amended. Your therapist is required to restrict the disclosure of PHI about you, the patient, to a health plan, upon request, if the disclosure is for the purpose of carrying out payment or healthcare operations and is not otherwise required by law. The PHI must pertain solely to a healthcare item or service for which you have paid the covered entity in full. (OCR clarifies that the adopted provisions do not require

that covered healthcare providers create separate medical records or otherwise segregate PHI subject to a restrict healthcare item or service; rather, providers need to employ a method to flag or note restrictions of PHI to ensure that such PHI is not inadvertently sent or made accessible to a health plan.)

The 2013 Amendments also adopt the proposal in the interim rule requiring your therapist**,** to provide you, the patient, a copy of PHI to any individual patient requesting it in electronic form**.** The electronic format must be provided to you if it is readily producible. OCR clarifies that your therapist must provide you only with an electronic copy of their PHI, not direct access to your electronic health record systems. The 2013 Amendments also give you the right to direct your therapist to transmit an electronic copy of PHI to an entity or person designated by the you. Furthermore, the amendments restrict the fees that your therapist may charge you for handling and reproduction of PHI, which must be reasonable, cost-based and identify separately the labor for copying PHI (if any). Finally, the 2013 Amendments modify the timeliness requirement for right of access, from up to 90 days currently permitted to 30 days, with a one-time extension of 30 additional days.

XI. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on Jan. 30, 2013

I acknowledge receipt of this notice

Client Name: _____

Parent/Legal Guardian Name: _____

Date: _____Signature: _____

Hill Country Therapy & Testing
Information Sheet- Adult Client

NAME: _____

MALE/FEMALE: _____

ADDRESS: _____

TELEPHONE: Cell: _____ Work/Home.: _____

D.O.B.: _____ Age: _____

HIGHEST GRADE/DEGREE: _____

OCCUPATION/POSITION: _____

REFERRED BY:_____

MARITAL STATUS: _____

PARTNER NAME: _____

PARTNER OCCUPATION: _____

METHOD OF PAYMENT: Cash Check Credit Card

Payment: If Rebecca Sheehan is in-network, insurance will be billed, but the insurance reviews the final bill prior to deciding final coverage, and I am responsible for any remaining balance. I understand this responsibility of payment. I give authorization for payment of insurance to be made directly to Rebecca Sheehan for rendered services. If out-of-network insurance, I will pay the full amount or make the agreed upon payments at the beginning of the feedback session and will be provided with an invoice by my therapist that I can forward to my insurance for filing the out-of-network claim. If I am privately paying, the full amount is due at the beginning of the session.

Responsible Party:_____

Client/Parent/Legal Guardian Signature:_____

Date:_____

Hill Country Therapy & Testing

PAYMENT AGREEMENT

Self Pay Rates

Psychotherapy	$ 125	per 50-60 minute session
Family Therapy	$ 200	per 50-60 minute session
Couples Therapy	$ 200	per 50-60 minute session
Legal Fees	$300	per hour, $75 per 15 minutes
Copying Records	$.25	per page
Letters	$30	per 30 minutes

Working with Insurance

I do not accept insurance at this time. I can provide you with documentation that you can submit for out-of-network benefits. Full fee payment is expected at the time of service.

Missed Appointments

24 hours notice of cancellation is required.

Less than 24 hours or no notice of cancellation:	$125 fee per late or no notice cancellation*
After 3rd missed appointment:	$150 fee per late or no notice cancellation*

A credit card is kept on file and the above cancellation fees will be charged at the time of the scheduled service.
Credit Card #_____ Exp. Date: _____
Security Code _____ Name on Card _____
Billing Zip Code _____

I understand and agree to all of the above information.

Name of Patient: _____
(please print) Last First Middle

Signature:_____Date:_____